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PRINTED: 11/04/2013

FORM APPROVED

OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

445215

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

10/30/2013

NAME OF PROVIDER OR SUPPLIER

HERITAGE CENTER, THE

STREET ADDRESS, CITY, STATE, ZIP CODE
1026 MCFARLAND STREET
MORRISTOWN, TN 37814(X4) ID
PREFIX
TAGSUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)ID
PREFIX
TAGPROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)(X5)
COMPLETION
DATE

F 000 INITIAL COMMENTS

During the annual recertification survey, and investigation of complaint numbers 32566 and 32679, conducted on October 28-30, 2013, at The Heritage Center, no deficiencies were cited related to complaint number 32679, under 42 CFR Part 483.13, Requirements for Long Term Care.

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET
SS=D PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, review of the facility investigation, and interview, the facility failed to follow physician's orders for side rails for one (#237) resident of forty-eight residents reviewed.

The findings included:

Resident #237 was admitted to the facility on August 2, 2013, and readmitted to the facility on August 31, 2013, with diagnoses including Urinary Tract Infection, Anemia, and Acute Kidney Failure.

Medical record review of the Fall Risk Evaluation dated September 1, 2013, revealed the resident was at risk for falls.

Medical record review of the care plan dated August 9, 2013, revealed "...Potential for Injury; Increased risk for falls...Side rail(s) as an enabler

F 000 The Heritage Center is committed to upholding the highest standard of care for its residents. This includes substantial compliance with all applicable standards and regulatory requirements. The facility respectfully works in cooperation with the State of Tennessee Department of Health toward the best interest of those who require the services we provide.

F 281 While this Plan of Correction is not to be considered an admission of validity of any findings, it is submitted in good faith as a required response to the survey conducted October 28-30, 2013. This Plan of Correction is the facility's allegation of substantial compliance with Federal and State Regulations.

281 SERVICES PROVIDED MEET
PROFESSIONAL STANDARDS

CORRECTIVE ACTION:

Resident #237 is no longer a resident in the facility.

10/30/13

RESIDENTS WITH POTENTIAL TO BE
AFFECTED:

All residents have the potential to be affected. A review of residents with side rail orders will be done by the Director of Nursing and/or designee to assure order accuracy and that the ordered side rail types are in place. Care plans will be reviewed by the MDS Coordinator(s) and updated to reflect the correct side rail/order information. Completion date 12/14/13.

12/14/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2013
NAME OF PROVIDER OR SUPPLIER HERITAGE CENTER, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1026 MCFARLAND STREET MORRISTOWN, TN 37814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	Continued From page 1 1/2 rails x 2..."	F 281	<u>SYSTEMIC CHANGES:</u> Nursing staff will be in-serviced by the Director of Nursing, Assistant Directors of Nursing, or designee on obtaining side rail orders with monitoring in place for correct usage and monitoring. Completion date 12/14/13.	12/14/13	
	Medical record review of a physician's order dated August 31, 2013, revealed "...Fall precaution 1/2 SR (siderail) x 2 for bed safety (and) mobility..."		<u>MONITORING:</u> The Director of Nursing, Assistant Directors of Nursing, or designee will audit side rail orders and usage for accuracy weekly x 3 months. The audits will be taken to the Performance Improvement Committee x 3 months for further interventions if indicated. Performance Improvement Committee members include the Executive Director, Director of Nursing, Assistant Directors of Nursing, Medical Director, Staff Development Coordinator, and Department Managers.	12/14/13	
	Medical record review of the Nurse's Note dated September 14, 2013, at 10:20 p.m., revealed "...This nurse alerted by CNA (certified nursing assistant) staff that Res. (resident) was found on floor by laundry aide. Res was in between...and room-mates bed...was laying on all of...bed clothes-top sheet (and) spread included...resident lying on...(right) side on...pillow asleep, the way (resident) was lying...appeared to be comfortable...Res. assessed from head to toe. Res. face was flushed (and) some older bruising noted to bilat (bilateral) arms, but no injuries noted. Res. alert (and) answering questions appropriately asked res 2-3 times if...was ok states "yes, yes I'm fine" asked res if...hit...head, states "No, I'm fine." (vital signs) (temperature) 97. (pulse) 117. (respirations) 20 (blood pressure) 145/61, O2 sat (oxygen saturation) 95%...Res. assisted up to bed-denies pain. New orders put in place for low bed (with) mats at bedside (and) non skid socks..."				
	Medical record review of the Nursing Progress Note dated September 15, 2013, at 5:50 a.m., revealed "...Entered res. room to admn. (administer) a.m. meds.(morning medications)...Res. right siderail raised, left siderail down..."				
	Review of a witness statement (regarding the incident on September 14, 2013) dated September 15, 2013, obtained by the facility from				

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F 281	<p>Continued From page 2</p> <p>Licensed Practical Nurse (LPN) # 1, revealed "...went to room and (resident #237)...lying in floor in between beds. All covers (and) pillow was in the floor, and res was lying on top of them (with) the pillow under...head. I checked res. head to toe...I ask (resident) what...was doing in the floor (resident) said I was just getting that chair...chair was on the other side of the room...since (resident) was lying on covers from bed and...head on a pillow I thought...had made...a bed (and) lay down in floor...I asked res if...was ok 3 X's (resident) said yes..."</p> <p>Interview on October 29, 2013, at 3:40 p.m., with the Assistant Director of Nursing (ADON), in the conference room, confirmed two side rails were not in place at the time the resident was found on the floor on September 14, 2013.</p> <p>Interview on October 29, 2013, at 4:15 p.m., with LPN #1, confirmed the resident was alert and oriented when found in the floor, was able to answer all questions appropriately and when asked if the resident fell, the resident said no, just made a bed.</p> <p>Interview on October 30, 2013, at 7:40 a.m., with Registered Nurse Supervisor # 3, in the conference room, confirmed one siderail was in the raised position when the resident was found on the floor, and the resident was to have both siderails in the raised position.</p> <p>c/o #32566</p>	F 281			
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an</p>	F 441	<p>441 INFECTION CONTROL, PREVENT, SPREAD, LINENS</p>		

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F 441	<p>Continued From page 3</p> <p>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility</p>	F 441	<p><u>CORRECTIVE ACTION:</u> Associate #3 and chef #1 were re-educated/in-serviced by the Director of Nursing and/or Dietary Manager on the practices of infection control during meal service. Completion date November 13, 2013.</p> <p><u>RESIDENTS WITH POTENTIAL TO BE AFFECTED:</u> All residents have the potential to be affected. Infection control policies surrounding food service have been reviewed by the Director of Nursing and Staff Development Coordinator as of November 13, 2013. Hand sanitization products have been placed in various areas of the dining room by the Director of Nursing and/or designee to assist in infection control compliance as of November 13, 2013.</p> <p><u>SYSTEMIC CHANGES:</u> All staff will be re-educated/in-serviced by the Staff Development Coordinator or Director of Nursing, Assistant Directors of Nursing, or designee on infection control policies/practices with focus on meal services. Completion date 12/14/13.</p>	11/13/13	11/13/13
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F 441	<p>Continued From page 4</p> <p>failed to maintain infection control practices during a meal service for one of three dining rooms observed.</p> <p>The findings included:</p> <p>During dining observation on May 28, 2013, beginning at 11:48 a.m., in the main dining room, Certified Nurse Assistant (CNA) #3 was observed to retrieve trays from a tray cart, and place the plated food in front of residents sitting at three different tables. Continued observation revealed CNA #3 was observed to touch the face and beard without washing or sanitizing the hands between serving residents.</p> <p>Interview with CNA #3 on Oct 28, 2013, at 11:55 a.m., in the main dining room, confirmed the CNA had not washed or sanitized the hands between food service of the four residents. Continued interview confirmed the CNA had wiped the CNA's mouth, and touched the CNA's beard without washing or sanitizing the hands. Further interview with CNA #3 confirmed the CNA did not know where the hand sanitizer was located in the main dining room, and confirmed the dining room did not have a sink available to wash the hands.</p> <p>During dining observation on October 28, 2013, at 11:56 a.m., in the main dining room, Chef #1 was observed wiping the Chef's nose with the back of the Chef's hand on two different occasions, and did not change gloves or sanitize the hands before continuing to plate food for the residents in the main dining room.</p> <p>Interview with Chef #1 on May 28, 2013, at 12:00 p.m., in the main dining room, confirmed the Chef had wiped the Chef's nose, and not changed</p>	F 441	<p><u>MONITORING:</u></p> <p>The Executive Director, Director of Nursing, Assistant Directors of Nursing, Dietary Manager and/or designee will audit meal service for one meal daily x 30 days for infection control compliance. Audit will be reviewed in Performance Improvement meeting following completion for infection control compliance and for any further interventions. Performance Improvement Committee members include the Executive Director, Director of Nursing, Assistant Directors of Nursing, Medical Director, Staff Development Coordinator, and Department Managers.</p>	12/14/13	

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NAME OF PROVIDER OR SUPPLIER

HERITAGE CENTER, THE

STREET ADDRESS, CITY, STATE, ZIP CODE
1028 MCFARLAND STREET
MORRISTOWN, TN 37814

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F 441 Continued From page 5
gloves or sanitized the hands before returning to
plating food for the residents.

F 441